descending colon, the sigmoid flexure and the rectum, more thickened and enlarged almost entirely at the expense of the mucous coat. The internal surface was converted into a mass of vegetations having the appearance of hemorrhoids. These vegetations run from $\frac{4}{10}$ to $\frac{6}{10}$ of an inch high, with a very enlarged base. In the intervals the surface is sometimes granular, sometimes smooth. In some cases the vegetant and granular forms are united. These lesions are due to infiltration of the mucous membrane by the eggs of the distoma, and if a microscopic examination be made of the submucous layer, it is seen to be full of the eggs, the same being true of the tubular glands. The eggs are ovoid, shaped like a pumpkin seed, about mm. 0.170 long, and often present a lateral spine, which is only found in the eggs of the intestinal tunics. In the urinary apparatus this spine is at one extremity of the egg. The eggs are undoubtedly laid in the hemorrhoidal veins, for it is here that the adults of both sexes are found. The mechanism of their passage through the walls of the vessels into the tissues is unexplained.

The second specimen presented was from a man dead of uræmia, in whose urine the eggs had been found during life. The kidneys were much enlarged, surfaces crumpled, containing cystic cavities, and the distinction between the cortical and medullary substance had disappeared, the renal structure was composed solely of an homogeneous layer, and was indurated. Some small pisiform abscesses were found in them. The ureters were enlarged and tortuous, the walls considerably thickened, the internal surface velvety. The walls of the bladder were enormously hypertrophied, and $1\frac{2}{10}$ inch thick, the cavity being about the size of a walnut. The hypertrophy was mostly at the expense of the muscular layer, which was very hard. Microscopic examination showed that the eggs existed in small quantity in the superficial layer of the vesical mucous membrane, the epithelium having disappeared. The right kidney presented the ordinary lesions of hydronephosis, the left those of advanced interstitial nephritis. The patient, then, had had cystitis caused by the eggs of the distoma, and this affection caused the lesions of the ureters and kidneys; for the eggs were not found in the kidney in this case, and are so found only exceptionally. The disease is not always fatal, as has been stated in certain works on the subject; the evidence of it being found in a great number of Arabs, some of whom recover.—*Journal de Méd. de Paris*, May 19, 1883.

Leucoderma.

Dr. THOMAS F. WOOD, of North Carolina, in describing a case of leucoderma, occurring in a negro woman, who had a carotid aneurism, but was otherwise in good health, says: The course of the increase of the area of leucoderma was not steadily progressive, but in waves. This patient was examined at varying intervals, and the margin of pigmented patches carefully traced upon her photograph. It was discovered that the black patches would recede on one side, and increase upon the other; and especially upon the face the margins were not so abruptly black at all times, but fading into the white by imperceptible gradation. The increase of absorption rapidly advanced in the five years preceding this writing, until now she has more the appearance of a blonde white woman with black patches on her face.

The condition of the skin is very peculiar. To the casual observer it appears much thinner than the skin of a negro, suggesting the idea of the obliteration of the rete mucosum. So highly sensitive is it that a moderate sun burns and the intense summer sun blisters it. The slightest scratch causes free bleeding, and nose-bleed is easily provoked, and recurs again and again. The nasal tract is exceedingly sensitive, and, as I have remarked in another place, does not bear out the theory of Mr. A. R. Wallace, that the deficiency of smell in some animals is due to the absence of pigment there, for this patient has unusual acuteness of this sense.

It is well known to those physicians who have watched syphilitic diseases among these people that the shade of their skin frequently changes to several degrees lighter, and that this change is permanent and uniform over the whole body. The lack of complete analogy between this sort of alphosis and leucoderma, strictly so-called, is that the transformation does not occur in patches.

I reported a case some years ago (1876) in the *London Medical Examiner* of a very black negro who had leucoderma succeeding typhoid fever. He had no white patches previously. His business was that of a sawyer, and exposure to the rays of the sun upon newly sawed lumber became very painful to him. This man's hair did not turn white, nor did his skin become so sensitive, and there was not that abrupt demarcation between the white and black as in the case above reported. After several years of rapid alphosis, pigmentation began again, and I am able to reaffirm what I previously reported, that the process still continues. The skin is not becoming so black as natural, but the change has been repeatedly noticed by his friends.

These three types of alphosis may lead us in the future to a more correct study of the causes. 1. We have leucoderma in a woman who had no noticeable change in her health from beginning to end. 2. We have the entire skin changing several hues lighter after an attack of constitutional syphilis. 3. We have a leucoderma succeeding convalescence from typhoid fever, in which there is resorption of pigment, and a gradual redeposit. Are these all examples of a different disease? Or are they different manifestations, varying degrees of a process which has a central origin elsewhere than in the skin?—*Journal of Cutaneous and Venereal Diseases*, June, 1883.

SURGERY.

Transplantation of Skin-Flaps from Distant Parts without Pedicle.

DR. J. R. WOLFE, Senior Surgeon to the Glasgow Ophthalmic Institution, has lately written an interesting paper on this subject (*Practitioner*, May, 1883), in which he says, that while practising M. Reverdin's method of skin-grafting in which little bits of the size of a pin's head are taken and arranged in mosaic fashion upon the ulcer, or upon the site of deficiency of the skin, he was never satisfied with the macadamized appearance of the parts. He also noticed a very important fact in connection with skin-grafting, namely, that the graft which was taken clean adhered satisfactorily, while the bits which had a bleeding under-surface did not adhere to their new site. He thus became convinced that the cause of non-success in transplantation was the areolar tissue underneath, and that, if we could transplant a skin-flap free of that subjacent tissue, we should secure its adhesion and incorporation. To put this to the test, he operated in one case in which the skin required for the eyelid was two inches in length by one inch in breadth. He removed the flap from the forearm in three portions, separating the first from its cellular tissue as closely as compatible with the integrity of the flap, but turning up the other two after removal, and with a knife slicing off the areolar tissue so as to leave a white surface, which I then applied to the eyelid. The